MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, October 19, 2001
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Draft outline for the June report: modernizing the Medicare benefit package
Mae Thamer, Julian Pettengill

MR. HACKBARTH: Last, but certainly not least, is the draft outline for the June report on modernizing the benefit package.

MS. THAMER: Julian and I are here to discuss MedPAC's June 2002 report which is going to focus on the Medicare benefit package. We sent you an outline of the issues that we delineated that were related to the June 2002 report as we saw it, as well as we sent you different types of recommendations that could be made based on varying levels of specificity. Some recommendations could be very general overarching types of recommendations, and others could be much more specific.

The topic of the Medicare benefit package is a very important, interesting, and very critical topic. It's also a very broad topic that could go in a lot of different directions. Given our resources, we really wanted to focus our efforts, and we hope in this discussion to find out three important things from the Commission.

One of them is what approach you'd like us to take in looking at the Medicare benefit package. Secondly, what the Commission would like to achieve in the June 2002 report. And third, what, if any, types of information you think you would like to have to make appropriate recommendations.

Before we begin I'd like to just very quickly set the stage with a few salient points about the background of the current Medicare package. As you all know, when Medicare was enacted in 1965, the benefit package was designed at that time to emulate that of the working population. The same benefits were offered in basically the same manner.

As such, they focused on acute care services, especially hospital services. The main objective was to limit financial liability of elderly beneficiaries and their children. It was not designed with the health needs of an elderly population in mind, and provisions at that time did not address problems of the chronically ill as well as other preventive services and other services. In the ensuring 35 years there hasn't been any major restructuring of the Medicare benefit package, although there have been major changes in the benefits that are offered to the working population.

Calls to modernize the Medicare benefit package have usually cited substantial financial liability and risk of the beneficiaries. For instance, that less than half of all health care costs are borne by Medicare, and that there's no maximum spending to protect against catastrophic costs.

Another issue that's often cited in the need to modernize the Medicare benefit package is better access to modern medicine for elderly beneficiaries, particularly, the lack of outpatient drug coverage, chronic disease management techniques, and other innovations in geriatric medicine.

Finally, there are concerns about how appropriate the

benefit package is for specific subpopulations, like the disabled and those with end-stage renal disease.

We thought a good place to start this discussion might be to discuss the three options that we sent you. These were of many possible options and approaches of what could be achieved with the June 2002 report.

Just to quickly summarize the three options that we presented were that the June 2002 report could either develop a conceptual model that would assist policymakers to examine issues around the Medicare benefit package. Secondly, we could go further and develop specific recommendations, both in terms of the content and/or the financing for reforming the benefit package. Or third, we could delineate the next steps in terms of actually implementing a reformed or modernized Medicare benefit package.

One or more of these options are possible. So we thought this would be a good place to start the discussion.

MR. SMITH: An information question. When folks in '65 looked at the working population's coverage what was the model? Was it folks covered by an employer plan? Was it what you could buy across the table at Blue Cross?

MS. THAMER: I think it was the Blue Cross-Blue Shield plan.

MR. SMITH: How well does that -- if we tried to say today, we want a model, the coverage of the non-aged population, what would we do with folks without coverage? Or the changes in coverage as we've moved from more defined benefit to more DC-like options? I wonder as we think about the, yes, the update ought to reflect what folks did in 1965, whether or not we also need to think about what it is we're trying to emulate, and what are the differences at this moment.

MR. HACKBARTH: Other comments?

DR. REISCHAUER: I would think that what we should have here is a discussion of why we're concerned about this. In number two you listed a lot of more specific things than I would come up with as categories. I can see that there are four reasons why we might want a more expanded benefit package. The first is it would result in better health outcomes. When you cover something and you don't cover others that are proven, important inputs to good health like prescription drugs, clearly the end result can't be as good.

Secondly, you might want a more expansive benefit package because it's cheaper. What I mean is, it's cheaper to buy one coherent insurance package than it is to paste together two or three, as 87 percent of the people do.

Third, because it's easier to administer. That is both from the individual's perspective, the beneficiary's perspective and from the perspective of CMS and whoever is running that supplemental insurance policy, and providers. You don't have to ask, who's going to cover this other part. You know.

And finally, just reveal preference of the beneficiary, that they would like something better. That in a way is separate from everything else. If people want something, you should provide it in the form that they want. That's a way of organizing really what are then a lot of examples or dimensions to these items in

number two.

MS. THAMER: So in some of these, in the second and third example that you gave, you're looking at it from a societal perspective.

DR. REISCHAUER: Absolutely.

MS. THAMER: That's rather than just from the Medicare perspective.

DR. REISCHAUER: Right.

DR. NEWHOUSE: As I understood what you were asking here, you were proposing to develop the conceptual model and you were looking for guidance on going forward to specific recommendations on services and implementation. I didn't feel I knew enough at this point to comment on that. I think I would encourage you to start out that way and see how it goes.

I thought it we do get to specific recommendations there's an obvious problem that it could become the overloaded Christmas tree. I thought it was going to be incumbent on us to have some idea of cost on any specific benefit package. I don't think we want to get to how to finance the cost, but at least we should have some sense of order of magnitude of cost.

DR. LOOP: These are just some random thoughts as I read through this. One was what Joe just mentioned, and that is that you have to attach some financial projections any time you enlarge the coverage.

But let me start on the second page there under 1(a) when you're talking about catastrophic costs. There's a definition of a catastrophic illness, but it seems to me as the population ages that there are many chronic diseases now which if you add up the cumulative cost that these become catastrophic illnesses. The other point there -- so I would like to know how you define catastrophic costs and what percent of all cost is termed catastrophic.

The other thing is that you say Medigap policies are becoming increasingly unaffordable. If that's true, are there trends, people are buying less Medigap, or how do you support that?

Just as a practical point, by the time someone reaches Medicare a lot of the prevention or preventive measures are lost. If you're 65 and you've smoked four packs a day for 30 or 40 years, there's not a lot of prevention at that age that's going to help you. So I wonder whether we're going from health care -- I understand what you want to do is you want to get out of just the episodic illness. But you can also get a little bit too far into public health, because there's some -- back to the common sense part, there's a way where disease prevention actually stops as you get to a certain age.

So I don't know whether any of that is helpful, but those are my comments.

MR. PETTENGILL: I guess the only response I would make to that is that people become eligible for Medicare, the non-disabled, the elderly become eligible at 65 and many of them will be living another 30 years. Certainly I hope to. And if I have high blood pressure or I have high cholesterol or something like that in my fifties and early sixties and I roll into Medicare and

Medicare doesn't pay for any of the services that are designed to prevent the effects of those problems, then we've lost something. So it's relevant in that sense, even though the opportunities for effective prevention may decline.

DR. LOOP: Right, but that is largely secondary prevention as opposed to primary prevention.

MR. PETTENGILL: Yes.

MR. FEEZOR: I guess one observation. I am a little concerned when we set our minds toward saying, how can we bring Medicare up to what current coverages are? I think we need to do a little bit more crystal-balling and looking how they should --

With that, a few of us out on the left coast are trying to think through what, at least for the active employees, a better design, and quite honestly, a better reimbursement of the providers to actually manage care, manage the disease burden, and actually design, whether it's an open enrollment, rethinking that where you try to get commitment of a patient to a provider or provider system over a longer period of time, of where you begin to actually pay specific providers for three-year durational treatments, or care management I should say as opposed to treatments.

All I'm saying is, let's not get out mind-set of looking at where it is now because it very well -- I'm not sure quite honestly that we have the answers now in our health benefit design, and fear that particularly given the economy that that may be a little bit -- so let's stretch ourselves just one second. We're still fumbling with it, but it may be helpful along that line to share some of the information that the Pacicic Business Group on Health is getting ready to try to trot out as it tries to push the margin a little bit and how to rethink that.

The final thing is, and I think certainly both Joe and Floyd's comments about needing some sort of dollars -- it could be if we get into the Christmas tree decorating business that we think of tiering those optional packages. If that's the case, then I think it offers at least a construct by which Congress could give in to its real instincts to have all sorts of great designs. But something between its payment, maybe rethinking the tax consequences specifically with regards to maybe longer term care, that is something that we could at least allow Congress to think -- think through for Congress a little bit on that.

DR. REISCHAUER: Going back to your outline, there's a whole lot that would be covered here and I was looking through it thinking, what would I drop? What I'd drop is number seven, the various restructuring approaches most commonly advocated for reforming the Medicare benefit package. That's a book and-a-half in and of itself. It strikes me that it's not that relevant.

There is one relevant issue and that is the question of whether Medicare should have a standard benefit package or some choice. But that can be mixed with almost any one of the structural alternatives. Even that gets into a very complicated set of both practical and philosophical issues. So I would treat that issue pretty succinctly, given what else we have on our plate here.

MS. THAMER: That's very helpful. That narrows it down a

great deal.

MR. MULLER: Since the cost and benefit question is going to be with us for many years to come, as it has for many years in the past, and just some of the words Allen has spoken to. In looking at the clinical management processes as part of the benefit package I think is something that would be fruitful for us to look at. Obviously, some of the efforts at capitation have been politically rejected in the last five or seven years.

But the ways in which -- the demand for services I think is just going to continue to go up for all the reasons that people have written aobut, including Joe and others in terms of the advance of technological and the consumerism. I think if we put into the benefit package as well as some consideration of the clinical management options that might be available, wehther it's stuff that's been tried out the last few years like disease management and some of the other kinds of experiments with overall case management, care management. But I think making that part of the benefit package, the modernization package would be fruitful for us to look at.

DR. LOOP: In the goals of modernizing the Medicare benefit package, I would also add to that A through G is beneficiary education, because that's going to do more for prevention and even disease management if you have an educated beneficiary public. I think that should be included.

MR. FEEZOR: Is that education or engagement?

DR. LOOP: Isn't engagement part of education though?

MS. THAMER: You also mean self-management, education in self-management as well as education in terms of lifestyle and behavior?

DR. LOOP: Yes, all of those. We can probably say you have to be educated first about, not so much accessing the system, but their own disease prevention, early, before they get to Medicare.

MS. RAPHAEL: I just wanted to build on the point that David made and just trying to understand what it is we're trying to emulate and what's happened in the employer-based insurance field. But I'd also like to imbed in that something that I think is important, which is in the employer-based insurance field, as an employer we will change our carrier every two to three years. So carriers don't have any incentive really to do a lot of the things that we might be examining in this chapter. But Medicare is the carrier forevermore. I think that is very important in looking at the equation here.

MR. SMITH: Three quick points. I think Bob is absolutely right about seven, and I think some of the same concern is in part three of the outline. That there may be too much program design in three rather than a focus on the benefit package.

Carol raises a point which I had also wanted to raise, except I'd broaden it a little bit. One of the things we ought to think about as we think about the Medicare benefit package is integration with the rest of the health care insurance delivery apparatus. We've raised that question in a variety of other ways. We certainly ought to think about the implications for system integration as we think about changes in the benefit package or the way it's delivered.

This is my last point. The third point is, following Allen, I would add long term care to part two.

MS. THAMER: The goals in modernizing?

MR. SMITH: Right.

MS. THAMER: And what would you say about it?

MR. SMITH: It seems to me that section two at the moment -- it's a wish list that runs some risk of turning into a Christmas tree. But as a wish list it's incomplete without long term care on it.

MR. PETTENGILL: David, could you be a little bit more specific about what you have in mind when you're talking about the system integration issues? Because I can see a lot of different things that we might want to worry about in the report, but I'm not sure which of them you're thinking of.

MR. SMITH: I'm not sure, Julian, I know how to be terribly specific. It seems to me that a couple of things that we know are going on and will continue to go on at a greater rate. Medicare will become a bigger and bigger part of the payment apparatus for the health care system as a whole. What are the implications for how Medicare pays, and what it pays for the rest of the system, which in relevant terms will be getting smaller? As baby-boomers age, as all of us become beneficiaries rather than commissioners, that will have an effect on the health care system beyond the boundaries of Medicare.

I don't know what's going on in the Medigap market. The questions Floyd raises are correct. But as we change the Medicare package that has implications for collectively bargained plans, for employer-provided retiree plans. So there are consequences, systemic consequences and in some cases financial consequences beyond Medicare that will intensify. Simply for demographic reasons we ought to pay attention.

MR. PETTENGILL: VA, DOD, secondary payer. There's a whole bunch of things.

MR. SMITH: Right.

DR. WAKEFIELD: I think the criteria section I thought were really important, the very last section in this document. So much so I almost thought it might be the first section that we think about in terms of informing policymakers. So two comments about it.

First of all, it might just be the wording and me for the first item (a), does it advance the practice of medicine, et cetera. I was looking at that a little bit more broadly. And then, does it high quality health care practices using the least costly means to arrive at a given beneficiary health outcome maybe, or beneficiary outcomes? I'm not sure. But it's much more than, in a sense of just the practice of medicine, I think. We're talking about care delivered in different settings and yada, yada. So you might think about that a little bit.

Then I wondered, was there any particular reason why you might not have included a criterion that talked about the need for policymakers to either consider or maintain comparability or equity among beneficiaries or across beneficiaries in terms of benefits and cost of the program?

MS. THAMER: We did not. We just didn't include it.

DR. WAKEFIELD: Would you think about that?

MS. THAMER: Okay.

MR. HACKBARTH: We're getting to the point where I feel we're going to start to lose commissioners, and this is a report where we have some more time to develop. Could I change the diretion here for a second and get people to turn to the last page which has three categories, types of recommendations, to try and define the right pitch, if you will, here. I'd like to see here what response commissioners had to the type -- where we ought to be headed. And if you don't have any thoughts, I guess that's okay too. But I wanted to make sure people had the opportunity.

It doesn't sound like we're getting any reaction.

DR. ROSS: Let me just tell you what we were trying to do there, because we've brought you outlines before and they're almost, by their nature, unobjectionable. But we were trying to get at issues we talked about at the retreat in terms of what will be the value added for the Commission's report. Just to think about these recommendations as 30,000 feet, 5,000 feet, ground level, which could you envision making, and whether any of these either set off peals of joy or terror in your hearts. The answer is, I guess, none of the above, and you want more structure. So we'll bring that to you.

MR. HACKBARTH: The issue, of course, isn't the content of what's here. We're trying to flesh out our vision of what we're trying to produce in June.

DR. ROSS: Because obviously we would like to go beyond endorsements of motherhood and apple pie and get to something more specific. Then the question is, how specific ought that to be.

DR. NELSON: Murray, if you want opinions on that issue, I like the type B recommendations because you get into a hornet's nest of turf battles and all that we just don't really need to insinuate ourselves in if we get very heavily into type C.

DR. REISCHAUER: Some of the type C recommendations really could be text of the discussion of the type B.

MR. SMITH: My sense, Alan, was that B was better than A, and C was better than B. And we ought to shoot for C and we'd end up at B with exactly what Bob described.

DR. REISCHAUER: I can see some type A recommendations, a mix of A and B.

MR. FEEZOR: Glenn, if I might, just one context, following on David's comment. We assumed that, and certainly the Medicare supp market is going to be there, but again you referenced it almost in passing, the importance of employment-based coverage to supplement on the retiree.

I think we need to at least put in the broader context what is happening to that, because I think that may cause Congress to revisit, if it is in fact going to visit how this program is designed. It was designed in the '60s because there was almost a total absence of coverage for people of that age. While we have greater prevalence of that now, either self-purchased or employment-purchased, certainly the employer sponsored is on a very drastic down

-- it's got a glide path -- so hence, I think that context needs to be highlighted as one of the issues presented in our report.

MR. HACKBARTH: Mae, Julian, anything else you need from us in terms of direction?

MR. PETTENGILL: No. We'll get much better reaction when we put a draft in front of you and we get to see what we're suggesting that you say and see whether you like it. Thank you.